STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was for an initial home health state licensure survey. Survey dates: February 15, 16, and 17, 2012 Facility: #012722 Medicaid Vendor: N/A Surveyors: Bridget Boston, RN, PHNS Tonya Tucker, RN, PHNS Census: 7 Skilled 4 Aide only: 2 Homemaker only: 1 Home Vitis: 3 Quality Review: Joyce Elder, MSN, BSN, RN March 1, 2012 This survey was modified 6/1/12. je	N 000		
N 440	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. This RULE is not met as evidenced by: Based on review of agency documents and personnel roster and interview, the agency failed to ensure all personnel providing services for the	N 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 440	Continued From page 1 agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed. The findings include: 1. A review of the organizational chart identified the director of nursing / administrator directed the "Field Staff " and listed the disciples registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, physical and occupational therapists all together, as equals, without any delineation of responsibility. The chart failed to include the medical social worker. 2. A review of the personnel roster failed to evidence physical and occupational therapists were employees or contract employees of the agency. The employee roster did include a medical social worker that was not identified on the organizational chart. 3. At 11:08 AM on February 15, 2012, the administrator indicated the agency did not employee therapists and that all physical, occupational, and speech therapists were contracted.	N 440		
N 444	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:	N 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 444	Continued From page 2 (1) Organize and direct the home health agency's ongoing functions. This RULE is not met as evidenced by: Based on clinical record, personnel record, hospital record, and agency document review; observation; and interview, the administrator failed to organize and direct the agency's functions. The findings include: 1. The administrator failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed. (See S 440) 2. The administrator failed to ensure, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed (See S 446 and S 596). 3. The administrator failed to implement a budgeting and accounting system for the current fiscal year ending 12/31 for 1 of 1 fiscal year reviewed. (See S 448) 4. The administrator failed to ensure the agency met the requirements for licensure. (See N 449) 5. The administrator failed to ensure a limited criminal history or expanded criminal history was applied for within 3 business days of employment and included a search back to the employee's 18th birthday for 10 of 12 employee files reviewed of employees that required a limited criminal	N 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 444	Continued From page 3 history, employee files contained documentation of job orientation for 12 of 12 files reviewed, and documentation evidenced the social worker was qualified for 1 of 1 social worker file reviewed. (See S 458) 6. The administrator failed to ensure all employees had a physical exam within 180 days of first patient contact that identified the employee was free from communicable disease for 11 of 12 files reviewed (See S 462) 7. The administrator failed to ensure Tuberculosis screenings with a two step Mantoux was completed upon hire if the employee did not have a negative tuberculin test within the previous twelve months or a chest x ray report was included for positive reactors for for 8 of 12 files reviewed. (See S 464) 8. The administrator failed to ensure the confidential medical records of employees were maintained in separate medical file and treated as confidential for 12 of 12 employee files reviewed. (See S 466) 9. The administrator failed to ensure written contracts included all the required items for 1 of 1 physical therapy contract reviewed. (See S 478) 10. The administrator failed to ensure the contracted providers maintained and made available personnel files for review for 1 of 1 contracted physical therapist file reviewed. (See S 482) 11. The administrator failed to ensure the agency developed and implemented a policy requiring a 5 day notice of discharge for 1 of 1 agency. (See N 488)	N 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 444	Continued From page 4 12. The administrator failed to ensure the patients were informed of the right that their family or legal representative may exercise the patient's rights as permitted by law for 5 of 5 records reviewed. (See S 496) 13. The administrator failed to ensure that patients were informed of their right to voice grievances regarding treatment that is or failed to be furnished, lack of respect for property by anyone providing services on behalf of the agency and that the patient or representative will not be subjected to discrimination or reprisal for grievances voiced for 5 of 5 records reviewed. (See S 500) 14. The administrator failed to ensure the patients were informed of the right that the patient or their representative has the right under Indiana law to access the patient's clinical record for 5 of 5 records reviewed. (See S 510) 15. The administrator failed to ensure patients were informed that the home health agency must investigate complaints made by the patient or patient's family or legal representative regarding treatment or care that is or fails to be furnished and/or the lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency and document both the existence of the complaint and the resolution of the complaint for 5 of 5 records reviewed. (See S 514) 16. The administrator failed to ensure the patient's needs were adequately met in the home in 1 of 1 record reviewed with patient harm resulting in the potential to affect all the agency's patients. (See S 520)	N 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 444	Continued From page 5 17. The administrator failed to ensure appropriate staff were available to meet the patient's needs in the home in 1 of 1 record reviewed with patient harm. (See S 522) 18. The administrator failed to ensure a medical plan of care was developed and included all the required items for 2 of 3 clinical records reviewed in which the patient was provided with a skilled service. (See S 524) 19. The administrator failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (See S 527) 20. The administrator failed to ensure the clinical records included a nursing plan of care for 3 of 3 patient records reviewed of patients receiving home health aide only services. (See S 533) 21. The administrator failed to ensure the registered nurse made an initial assessment visit to identify the patients' immediate care needs as required by agency policy for 3 of 5 clinical record reviewed. (See S 540) 22. The administrator failed to ensure the registered nurse established a plan of care for 4 of 5 clinical records reviewed. (See S 542) 23. The administrator failed to ensure the registered nurse informed the physician of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (See S 546)	N 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 444	Continued From page 6 24. The administrator failed to ensure the registered nurse carried out the physician orders which were obtained by the agency for the evaluation of the patient for home health services in 3 of 3 clinical records reviewed of patients who which received skilled services. (See S 547) 25. The administrator failed to ensure the physical therapist completed the initial assessment visit within forty eight hours of referral as required by agency policy in 2 of 2 clinical records reviewed of patients receiving physical therapy only. (See S 562) 26. The administrator failed to ensure a qualified social worker provided services as ordered in 1 of 1 record reviewed with orders for a social worker. (See S 572) 27. The administrator failed to ensure documentation evidenced that, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed. (See S 598)	N 444		
N 446	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.	N 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 446	Continued From page 7 This RULE is not met as evidenced by: Based on personnel record, clinical record, and document review and interview, the administrator failed to ensure, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed (G, H, I, J, K, and L). Findings include: 1. During an interview on 2/15/12 at 12:50 PM, the Director of Nurses indicated she completed all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient. 2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number. 3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program" states, "Home Health Aides prior to providing patient service should have the following areas addressed: Successful completion of a competency evaluation program. ... Have documentation which demonstrates successful	N 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 446	Continued From page 8 completion of a competency evaluation." 4. The policy titled "Section 03.13 - Clinical Competency Program" states, "BrightStar Care will access and document the clinical competency of each staff member who provides direct client care, treatment, or services. Each staff member who provides direct client care will have a clinical competency assessment at defined intervals: a. as part of orientation, ... in accordance with laws and regulations." 5. Employee files G, H, I, J, K, and L included the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant." The skills included on the check list were "1. Temperature - digital thermometers, oral, axillary, temporal, tympanic. 2) Pulse - radial. 3) Pulse - apical. 4) Blood Pressure. 5) respirations., 6) shower / tub bath. 7) bed bath. 8) skin care. 9) oral care. 10) shampoo. 11) toileting / elimination: urinal, bedpan, bedside commode. 12) transfer: bed to chair, chair to standing, assist with ambulation, and other. 13) assists with range of motion. 14) assistive devices: walker, cane, other. 15) positioning. 16) making occupied bed. 17) Miscellaneous skills: Medication reminder, Urinary catheter care, gastrostomy site care, observe / record intake / output, other, and other. ... 27) Meal Preparation: feeding, diabetic diet, low sodium, low cholesterol / fat diets." The form was to be initialed and dated by the individual evaluating the skill. The proficiency method code at the bottom of the page stated, "O" for observation, "D" for demonstration, and "ST" for special training. The list did not include range of motion. 6. Personnel file G, date of hire 6/3/11 and first patient contact 12/14/11 with patient #4,	N 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 446	Continued From page 9 evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" that documented skills were evaluated on 6/21/11, 8/31/11, 12/7/11, and 1/10/12 (after patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, and 4) meal preparation, diabetic, low sodium, low cholesterol /fat diets. The document evidenced the aide was evaluated as competent in an additional task and written in as "catheter flush" that was not dated. This task is not in the scope of practice of the home health aide. 7. Personnel file H, date of hire 5/18/11 and first patient contact 12/13/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" that documented skills were evaluated on 6/7/11, 6/8/11, 8/31/11, 12/13/11, and 12/30/11 (after first patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, urinal, bedpan, or bedside commode, and 5) meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" on 12/13/11 and "basic wound care" 12/20/11. These tasks are not in the scope of practice of the home health aide. 8. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 10/20/11, 12/11/11, and 12/18/11 (after patient contact). The document failed to	N 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 446	Continued From page 10	N 446		

evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) toileting or elimination, urinal, bedpan, or bedside commode, and 4) meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" on 12/18/11. These tasks are not in the scope of practice of the home health aide.

9. Personnel file J, date of hire 11/1/11 and first patient contact 12/24/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 11/1/11, 11/9/11, and 12/24/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, urinal, bedpan, or bedside commode, and 4) feeding, or meal preparation of a low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/24/11. These tasks are not in the scope of practice of the home health aide.

10. Personnel file K, date of hire 6/22/11 and first patient contact 12/24/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 7/8/11, 9/8/11, 12/8/11, and 12/15/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, bedpan, or bedside commode, and 4) feeding, or meal preparation of a diabetic, low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 446	Continued From page 11 sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/15/11. These tasks are not in the scope of practice of the home health aide. 11. Personnel file L, date of hire 12/28/11 and first patient contact 12/31/11, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 12/30/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, and 3) toileting or elimination, bedpan, or bedside commode. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/30/11. These tasks are not in the scope of practice of the home health aide.	N 446		
N 448	410 IAC 17-12-1(c)(5) Home health agency administration/management Rule 12 Sec. 1(c)(5) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (5) Implement a budgeting and accounting system. This RULE is not met as evidenced by: Based on policy and document review and interview, the administrator failed to implement a budgeting and accounting system for the current fiscal year ending 12/31 for 1 of 1 fiscal year reviewed.	N 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 448	Continued From page 12 Findings include: 1. On 2/17/12 at 1 PM, the administrator indicated she had not implemented any annual budgets. 2. The undated policy titled "Section 01.01 A BrightStar Healthcare Governing Body By Laws" states, "Authority and Responsibility for the overall, day to day operations of BrightStar Healthcare shall be delegated to the Administrator. The administrator shall: ... Implement a budgeting and accounting system." 3. The undated policy titled "Section 01.01 - Governing Body" states, "The governing body shall be responsible to do the following: ... Oversee the management and fiscal affairs of the agency."	N 448		
N 449	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. This RULE is not met as evidenced by: Based on clinical record, personnel record, hospital record, and agency document review; observation; and interview, the administrator failed to ensure the agency met all the requirements for licensure.	N 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 449	Continued From page 13 The findings include: 1. The administrator failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed. (See S 440) 2. The administrator failed to organize and direct the agency's ongoing functions. (See N 444) 3. The administrator failed to ensure, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed (See S 446 and S 596). 4. The administrator failed to implement a budgeting and accounting system for the current fiscal year ending 12/31 for 1 of 1 fiscal year reviewed. (See S 448) 5. The administrator failed to ensure a limited criminal history or expanded criminal history was applied for within 3 business days of employment and included a search back to the employee's 18th birthday for 10 of 12 employee files reviewed of employees that required a limited criminal history, employee files contained documentation of job orientation for 12 of 12 files reviewed, and documentation evidenced the social worker was qualified for 1 of 1 social worker file reviewed. (See S 458) 6. The administrator failed to ensure all employees had a physical exam within 180 days of first patient contact that identified the employee was free from communicable disease for 11 of 12 files reviewed (See S 462)	N 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 449	Continued From page 14 7. The administrator failed to ensure Tuberculosis screenings with a two step Mantoux was completed upon hire if the employee did not have a negative tuberculin test within the previous twelve months or a chest x ray report was included for positive reactors for for 8 of 12 files reviewed. (See S 464) 8. The administrator failed to ensure the confidential medical records of employees were maintained in separate medical file and treated as confidential for 12 of 12 employee files reviewed. (See S 466) 9. The administrator failed to ensure written contracts included all the required items for 1 of 1 physical therapy contract reviewed. (See S 478) 10. The administrator failed to ensure the contracted providers maintained and made available personnel files for review for 1 of 1 contracted physical therapist file reviewed. (See S 482) 11. The administrator failed to ensure the agency developed and implemented a policy requiring a 5 day notice of discharge for 1 of 1 agency. (See N 488) 12. The administrator failed to ensure the patients were informed of the right that their family or legal representative may exercise the patient's rights as permitted by law for 5 of 5 records reviewed. (See S 496) 13. The administrator failed to ensure that patients were informed of their right to voice grievances regarding treatment that is or failed to be furnished, lack of respect for property by	N 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 449	Continued From page 15 anyone providing services on behalf of the agency and that the patient or representative will not be subjected to discrimination or reprisal for grievances voiced for 5 of 5 records reviewed. (See S 500) 14. The administrator failed to ensure the patients were informed of the right that the patient or their representative has the right under Indiana law to access the patient's clinical record for 5 of 5 records reviewed. (See S 510) 15. The administrator failed to ensure patients were informed that the home health agency must investigate complaints made by the patient or patient's family or legal representative regarding treatment or care that is or fails to be furnished and/or the lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency and document both the existence of the complaint and the resolution of the complaint for 5 of 5 records reviewed. (See S 514) 16. The administrator failed to ensure the patient's needs were adequately met in the home in 1 of 1 record reviewed with patient harm resulting in the potential to affect all the agency's patients. (See S 520) 17. The administrator failed to ensure appropriate staff were available to meet the patient's needs in the home in 1 of 1 record reviewed with patient harm. (See S 522) 18. The administrator failed to ensure a medical plan of care was developed and included all the required items for 2 of 3 clinical records reviewed in which the patient was provided with a skilled service. (See S 524)	N 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 449	Continued From page 16 19. The administrator failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (See S 527) 20. The administrator failed to ensure the clinical records included a nursing plan of care for 3 of 3 patient records reviewed of patients receiving home health aide only services. (See S 533) 21. The administrator failed to ensure the registered nurse made an initial assessment visit to identify the patients' immediate care needs as required by agency policy for 3 of 5 clinical record reviewed. (See S 540) 22. The administrator failed to ensure the registered nurse established a plan of care for 4 of 5 clinical records reviewed. (See S 542) 23. The administrator failed to ensure the registered nurse informed the physician of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (See S 546) 24. The administrator failed to ensure the registered nurse carried out the physician orders which were obtained by the agency for the evaluation of the patient for home health services in 3 of 3 clinical records reviewed of patients who which received skilled services. (See S 547) 25. The administrator failed to ensure the physical therapist completed the initial assessment visit within forty eight hours of	N 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 449	Continued From page 17 referral as required by agency policy in 2 of 2 clinical records reviewed of patients receiving physical therapy only. (See S 562) 26. The administrator failed to ensure a qualified social worker provided services as ordered in 1 of 1 record reviewed with orders for a social worker. (See S 572) 27. The administrator failed to ensure documentation evidenced that, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed. (See S 598)	N 449		
N 458	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. This RULE is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure a limited	N 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 458	Continued From page 18	N 458		

criminal history or expanded criminal history was applied for within 3 business days of employment and included a lifetime criminal history check for 10 of 12 employee files reviewed of employees that required a limited criminal history (Files A, C, D, F, G, H, I, J, K, and L), employee files contained documentation of job orientation for 12 of 12 files reviewed (files A, B, C, D, E, F, G, H, I, J, K, and L), and documentation evidenced the social worker was qualified for 1 of 1 social worker file reviewed (file A).

The findings include:

1. Personnel file A, date of hire 11/1/11 and first patient contact 1/14/12 with patient # 4, failed to evidence the employee met the qualifications of a social worker and was oriented to the job. The file contained a criminal history by Intellicorp on 11/15/11. It is unknown how far back the check went so it was unable to be determined if the check was a lifetime check.

410 IAC 19-9-25 defined a social worker and stated, "means a person who has a master's degree from a school of social work accredited by the Council on Social Work Education."

2. Personnel file B, date of hire 4/28/11 failed to evidence orientation to the job as the alternate administrator and alternate director of nursing.

3. Personnel file C, date of hire 6/3/11 and first patient contact 12/8/11 with patient # 4, evidenced the patient had lived out of state (Montague, Texas) during the last 2 years. The Intellicorp criminal history check was obtained 6/13/11 only went back 7 years for Montague, Texas, and does not include that Indiana was searched. The document states, "Multistate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 458	Continued From page 19	N 458		

criminal search" but does not identify which states. It is unknown how far back the check went so it was unable to be determined if the check was a lifetime check. The file failed to evidence orientation to the job as a licensed practical nurse.

4. Personnel file D, date of hire 4/13/11 and first patient contact 12/23/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 4/28/11 that only went back 10 years. The file failed to evidence orientation to the job as a registered nurse.

5. Personnel file E, date of hire 4/7/11, failed to evidence orientation to the job as the director of nursing and administrator.

6. Personnel file F, date of hire 9/15/11 and first patient contact 12/8/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 9/21/11, but does not indicate the check was a lifetime check. The file failed to evidence orientation to the job as a registered nurse.

7. Personnel file G, date of hire 6/3/11 and first patient contact 12/14/11 with patient # 5, evidenced an Intellicorp criminal history check was obtained on 6/14/11. The "Multistate criminal search" does not indicate which states were checked or if the search was a lifetime check.. The file failed to evidence orientation to the job as a home health aide.

8. Personnel file H, date of hire 5/18/11 and first patient contact 12/13/11 with patient # 4, evidenced an Intellicorp national criminal history check was obtained on 5/20/11 but did not indicate if the check was a lifetime check. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 458	Continued From page 20 file failed to evidence orientation to the job as a home health aide. 9. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 10/12/11 for Tippecanoe and Marian counties in Indiana. As an adult the employee has lived in White, Tippecanoe, Lake, and Marion counties. The document did not indicate if the search was a lifetime check. The file failed to evidence orientation to the job as a home health aide. 10. Personnel file J, date of hire 11/1/11 and first patient contact 12/24/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 11/3/11 for Lake County Illinois and Tippecanoe County Indiana. The search failed to evidence the years searched and it was unable to be determined if it was a lifetime check. The file failed to evidence orientation to the job as a home health aide. 11. Personnel file K, date of hire 6/22/11 and first patient contact 12/8/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 6/23/11 for a "Multistate Criminal Search" and Tippecanoe County Indiana. The search did not document it was a lifetime check. The file failed to evidence orientation to the job as a home health aide. 12. Personnel file L, date of hire 12/28/11 and first patient contact 12/31/11, evidenced an Intellicorp criminal history check was obtained on 1/4/12 for Tippecanoe, Pulaski, and White counties. The search failed to evidence it was a lifetime check. The file failed to evidence orientation to the job as a home health aide.	N 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 458	Continued From page 21 13. The undated policy titled "Section 03.05 - Personnel File" states, "Personnel files who provide direct patient care will contain the following at a minimum ... Limited criminal history ... documentation of orientation to their job." 14. On 2/15/12 at 1:15 PM, employee N indicated she did not realize until 2/15/12 that the contract with Intellicorp did not automatically check the Indiana Repository or complete a national search when the request for search was submitted. 15. On 2/16/12 at 4:35 PM, employee N indicated the personnel files reviewed were from a previous home health agency license and the agency did not conduct additional criminal history searches when the agency received their new license dated 12/8/12 and began to admit patients.	N 458		
N 462	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. This RULE is not met as evidenced by: Based on personnel file and policy review and	N 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 462	Continued From page 22 interview, the agency failed to ensure all employees had a physical exam within 180 days of first patient contact that identified the employee was free from communicable disease for 11 of 12 files reviewed (A, B, D, E, F, G, H, I, J, K, and L) with the potential to affect all the agency's patients. Findings include: 1. Personnel file A, date of hire 11/1/11 and first patient contact 1/14/12 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 2. Personnel file B, date of hire 4/28/11, the alternate director of nursing and alternate administrator, failed to evidence a physical exam was completed. Therefore, the alternate director of nursing was not able to perform or monitoring direct patient care in the event the administrator / director of nursing was incapacitated. 3. Personnel file D, date of hire 4/13/11 and first patient contact 12/23/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 4. Personnel file E, date of hire 4/7/11, the director of nursing / administrator and first patient contact 12/15/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 5. Personnel file F, date of hire 9/15/11 and first patient contact 12/8/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 6. Personnel file G, date of hire 6/3/11 and first	N 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 462	Continued From page 23 patient contact 12/14/11 with patient # 5, failed to evidence a physical exam was completed within 180 days of the first patient contact. 7. Personnel file H, date of hire 5/18/11 and first patient contact 12/13/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 8. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 9. Personnel file J, date of hire 11/1/11 and first patient contact 12/24/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 10. Personnel file K, date of hire 6/22/11 and first patient contact 12/8/11 with patient # 4, failed to evidence a physical exam was completed within 180 days of the first patient contact. 11. Personnel file L, date of hire 12/28/11 and first patient contact 12/31/11, failed to evidence a physical exam was completed within 180 days of the first patient contact. 13. The undated policy titled "Section 03.03 - Health Screening" states, "All agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients. ... A pre-employment physical examination will be performed by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact." 14. On 2/16/12 at 4:35 PM, employee N	N 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 462	Continued From page 24 indicated there were no more documents available for the personnel records.	N 462		
N 464	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB	N 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 464	Continued From page 25 assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. This RULE is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure Tuberculosis (TB) screenings with a two step Mantoux was completed upon hire if the employee did not have a negative tuberculin test within the previous twelve months or a chest x ray report was included for positive reactors for for 8 of 12 files reviewed (A, B, D, G, H, I, K, and L) with the potential to affect all the agency's patients. Findings include: 1. Personnel file A, date of hire 11/1/11 and first patient contact 1/14/12 with patient # 4, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 2. Personnel file B, date of hire 4/28/11, the	N 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 464	Continued From page 26 alternate director of nursing and alternate administrator, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 3. Personnel file D, date of hire 4/13/11 and first patient contact 12/23/11 with patient # 4, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 4. Personnel file G, date of hire 6/3/11 and first patient contact 12/14/11 with patient # 5, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 5. Personnel file H, date of hire 5/18/11 and first patient contact 12/13/11 with patient # 4, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 6. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report.	N 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 464	Continued From page 27 7. Personnel file K, date of hire 6/22/11 and first patient contact 12/8/11 with patient # 4, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 8. Personnel file L, date of hire 12/28/11 and first patient contact 12/31/11, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed within the previous twelve months or a chest x ray report. 9. The undated policy titled "Section 03.03 - Health Screening" states, "Tuberculosis testing: Any employee, staff member or contract personnel who provide care on behalf of the agency through direct patient care contact must be evaluated for tuberculosis. Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon - TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve months and the result was negative. If the individual does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within one to three weeks after the first tuberculin test was administered. 10. On 2/16/12 at 4:35 PM, employee N indicated there were no more documents available for the personnel records.	N 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 466	Continued From page 28	N 466		
N 466	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). This RULE is not met as evidenced by: Based on observation and interview, the agency failed to ensure the confidential medical records of employees were treated as confidential for 12 (files A, B, C, D, E, F, G, H, I, J, K, and L) of 12 employee files reviewed. The findings include: On 2/15/11 at 11:50 PM, employee N obtain the personnel files for review. The personnel files A, B, C, D, E, F, G, H, I, J, K, and L were individually stored in separate folders and the medical information was observed to be housed in individual and separate folders side by side in the same drawer that housed all of the other personnel information. Employee N indicated the health files were identified as a health file by the file jacket color and the other personnel file jackets were manilla in color and they were all kept together in the same desk drawer.	N 466		
N 478	410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts	N 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 478	Continued From page 29 are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. This RULE is not met as evidenced by: Based on review of agency contract and interview, the agency failed to ensure written contracts included all the required items for 1 of 1 contracted therapy provider. Findings include: 1. The administrator / director of nursing indicated on 2/15/12 at 11:08 AM the agency had only contracted therapists. 2. The contract titled "Independent Contractor Agreement" dated August 19, 2011, between Therapy, Etc. and the agency failed to include and specify 1) The the patients are accepted for care only by the primary home health agency; 2) the necessity to conform to all applicable home	N 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 478	Continued From page 30 health agency policies including personnel qualifications; 3) The responsibility for participating in developing plans of care; 4) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency; 5) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation; and 6) The procedures for payment for services furnished under the contract. 3. On 2/17/12 at 1 PM, the administrator / director of nursing indicated she was not aware that all of the requirements were to be part of the contract between the agency and the contracted therapy provider.	N 478		
N 482	410 IAC 17-12-2(f) Q A and performance improvement Rule 12 Sec. 2(f) When contracting temporary services from another licensed home health agency, organization, or independent contractor, the personnel records shall be maintained at the office of the employer and shall be available to the home health agency upon two (2) hours notice. This RULE is not met as evidenced by: Based on interview and review of personnel file and policy, the agency failed to ensure the contracted providers maintained and made available personnel files for review for 1 of 1 contracted physical therapist file reviewed (M). Findings include: 1. On 2/16/12 at 10:45 AM, personnel file M, physical therapist, contract date with agency	N 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 482	Continued From page 31 8/19/11 and first patient contact was on 12/20/11 with patient # 4, failed to evidence a limited criminal history or a expanded criminal history was completed by the contracted therapy Therapy Etc.. The file also failed to evidence a physical examination within 180 days prior to patient contact and annual monitoring for exposure to tuberculosis. The file evidenced one tuberculosis skin test was placed on 8/29/11; however, the document failed to evidence the skin test was read and the results were negative. 2. On 2/16/12 at 11:20 AM, employee E indicated the owner of the contracted therapy company was not able to produce a complete personnel file until 9 PM on 2/16/12 via fax or in person on 2/17/12. The contractor only requests evidence of a license from the therapists. She indicated she was unaware of the requirement for contracted providers. 3. The undated policy titled "Section 03.03 - Health Screening" states, "Tuberculosis testing: Any employee, staff member or contract personnel who provide care on behalf of the agency through direct patient care contact must be evaluated for tuberculosis. Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon - TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve months and the result was negative. If the individual does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within one to three weeks after the first tuberculin test was administered."	N 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 482	Continued From page 32 4. The contract dated August 19, 2011, titled "Independent Contractor Agreement" between BrightStar and the contracted therapy company Therapy Etc." failed to evidence Therapy Etc. would provide BrightStar with a current complete personnel file within 2 hours of the request.	N 482		
N 488	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped. (j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 488	Continued From page 33 This RULE is not met as evidenced by: Based on interview, the agency failed to ensure the agency developed and implemented a policy requiring a 5 day notice of discharge for 1 of 1 agency. Findings include: On 2/17/12 at 2:05 PM, employees E and N indicated the agency did not develop a policy requiring a notice of patient discharge at least five (5) days before services are stopped.	N 488		
N 496	410 IAC 17-12-3(b) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (1) The patient's family or legal representative may exercise the patient's rights as permitted by law. This RULE is not met as evidenced by: Based on patient rights document review and interview, the agency failed to inform patients of the patient's right that their family or legal representative may exercise the patient's rights as permitted by law for 5 (#'s 1-5) of 5 records reviewed. The findings include: 1. The agency document titled "Patient's Rights and Responsibilities" failed to evidence the patient right that the patient's family or legal representative may exercise the patient's rights as permitted by law. 2. Clinical records #1-5 evidenced the patients	N 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 496	Continued From page 34 had signed the document titled "Admission Packet and Acknowledgement Statement." The document included a list of items that were reviewed and received by the patient at the time of admission and included on the list was "Client Bill of Rights and Responsibilities." The agency failed to evidence a document titled "Client Bill of Rights and Responsibilities." 3. On 2/17/12 at 1:45 PM, employee N indicated the wrong Patient Right document was placed in the patient home folder. She indicated the Patient Right document was updated and should have been the document identified as policy # 02.06 and titled "Bill Of Rights" and there was no documentation the patients were informed of this specific right at the time of admission or following admission. She indicated this specific right was not on any of the the agency's three patient rights documents titled "Patient's Rights and Responsibilities, Section 02.06 - Bill of Rights, and Section 02.06 (A) - Bill of Rights Form."	N 496		
N 500	410 IAC 17-12-3(b)(2)(B) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. This RULE is not met as evidenced by: Based on the patient rights document review and interview, the agency failed to inform patients of	N 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 500	Continued From page 35 their right to voice grievances regarding treatment that is or failed to be furnished, lack of respect for property by anyone providing services on behalf of the agency and the patient or representative will not be subjected to discrimination or reprisal for grievances voiced for 5 (#'s 1-5) of 5 records reviewed. The findings include: 1. The agency document titled "Patient's Rights and Responsibilities" failed to evidence the patient right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. 2. Clinical records #1-5 evidenced the patients had signed the document titled "Admission Packet and Acknowledgement Statement." The document included a list of items that were reviewed and received by the patient at the time of admission and included on the list was "Client Bill of Rights and Responsibilities." The agency failed to evidence a document titled "Client Bill of Rights and Responsibilities." 3. On 2/17/12 at 1:45 PM, employee N indicated the wrong Patient Right document was placed in the patient home folder. She indicated the Patient Right document was updated and should have been the document identified as policy # 02.06 and titled "Bill Of Rights" and there was no documentation the patients were informed of this specific right at the time of admission or following admission. She indicated this specific right was not on any of the the agency's three patient rights	N 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 500	Continued From page 36 documents titled "Patient's Rights and Responsibilities, Section 02.06 - Bill of Rights, and Section 02.06 (A) - Bill of Rights Form."	N 500		
N 510	410 IAC 17-12-3(b)(3) Patient Rights Rule 12 Sec. 3(b)(3) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (3) The patient or patient's legal representative has the right under Indiana law to access the patient's clinical records unless certain exceptions apply. The home health agency shall advise the patient or the patient's legal representative of its policies and procedures regarding the accessibility of clinical records. This RULE is not met as evidenced by: Based on patient rights document review and interview, the agency failed to inform patients of the right that the patient or their representative has the right under Indiana law to access the patient's clinical record for 5 (#'s 1-5) of 5 records reviewed. The findings include: 1. The agency document titled "Patient's Rights and Responsibilities" failed to evidence the patient right that the patient or their representative has the right under Indiana law to access the patient's clinical record. 2. Clinical records #1-5 evidenced the patients had signed the document titled "Admission Packet and Acknowledgement Statement." The document included a list of items that were reviewed and received by the patient at the time	N 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 510	Continued From page 37 of admission and included on the list was "Client Bill of Rights and Responsibilities." The agency failed to evidence a document titled "Client Bill of Rights and Responsibilities." 3. On 2/17/12 at 1:45 PM, employee N indicated the wrong Patient Right document was placed in the patient home folder. She indicated the Patient Right document was updated and should have been the document identified as policy # 02.06 and titled "Bill Of Rights" and there was no documentation the patients were informed of this specific right at the time of admission or following admission. She indicated this specific right was not on any of the the agency's three patient rights documents titled "Patient's Rights and Responsibilities, Section 02.06 - Bill of Rights, and Section 02.06 (A) - Bill of Rights Form."	N 510		
N 514	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. This RULE is not met as evidenced by: Based on patient rights document review and interview, the agency failed to inform patients that the home health agency must investigate	N 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 514	Continued From page 38 complaints made by the patient, or patient's family or legal representative, regarding treatment or care that is or fails to be furnished and/or the lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency and document both the existence of the complaint and the resolution of the complaint for 5 (#'s 1-5) of 5 records reviewed. The findings include: 1. The agency document titled "Patient's Rights and Responsibilities" failed to evidence the patient right that the home health agency shall investigate complaints made by a patient or the patient's family or legal representative regarding treatment or care that is (or fails to be) furnished, the lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency, and will document both the existence of the complaint and the resolution of the complaint. 2. Clinical records #1-5 evidenced the patients had signed the document titled "Admission Packet and Acknowledgement Statement." The document included a list of items that were reviewed and received by the patient at the time of admission and included on the list was "Client Bill of Rights and Responsibilities." The agency failed to evidence a document titled "Client Bill of Rights and Responsibilities." 3. On 2/17/12 at 1:45 PM, employee N indicated the wrong Patient Right document was placed in the patient home folder. She indicated the Patient Right document was updated and should have been the document identified as policy # 02.06 and titled "Bill Of Rights" and there was no documentation the patients were informed of this	N 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 514	Continued From page 39 specific right at the time of admission or following admission. She indicated this specific right was not on any of the the agency's three patient rights documents titled "Patient's Rights and Responsibilities, Section 02.06 - Bill of Rights, and Section 02.06 (A) - Bill of Rights Form."	N 514		
N 520	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure appropriate staff were available to meet the patient's needs in the home in 1 of 1 record reviewed with patient harm resulting in the potential to affect all the agency's patients. (#4) Findings: 1. Clinical record # 4, evidenced a document titled "Initial Phone Call Assessment - INTAKE FORM" which indicated a family member called the agency on October 20, 2011, and indicated the patient was receiving treatment in an extended care facility at the time of the call. Documentation stated, "Had a stoke in May, has hemiparesis on right side, can move and standup but can dress self, ... need someone every day get down, get up, ... need someone full time, because family leaves for Florida." A. The record evidenced a document titled "SK1 - Initial Skilled Client Assessment" dated	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 40 12/8/11 at 5 PM, completed by employee F, which states, "Indwelling catheter, hemiparesis, right side weakness, use of assistive device ... slide board, psycho / neurologic alert, oriented person, place, forgetful, ... integumentary ... pressure ulcers Describe Skin Abnormalities: 2 cm [centimeter] unstageable 100 % covered with slough." The document included an area titled "Functional Screen" in which the assessor was to indicate the patient's level of function, the patient's ability or assistance level identified with a list of daily living tasks / activity. The assessor indicated by placing a check mark in the column that the patient was dependent on others for bathing / showering, dressing / undressing, toileting, preparing meals, eating, and use of telephone. The assessor indicated in same fashion that the patient required "human help - set up," assistance with transfers, hair care, oral care, shaving, bed mobility, medications, and eating. The assessor assessed and documented "Functional Screen" and indicated BrightStar would provide assistance with bathing, showering, dressing, undressing, and toileting. The assessment indicated the patient was incontinent of stool. The record failed to evidence the physician was notified of the wound, once identified, or an order for treatment was obtained by the nurse. The assessment failed to identify who were the primary caregivers, the tasks they were accepting, and their level of skill in caring for the patients needs as identified. B. The record evidenced a document titled "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" dated 12/8/11 with the discipline assigned, indicated with an X, to be aide. The services that were assigned to be performed by the aide were hygiene - bed - partial / complete daily, shampoo hair as needed, mouth care daily,	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 41	N 520		

shave electric as needed, skin care daily, dressing daily, catheter care daily, assist with feeding, and turning and repositioning every 2 hours.

C. The record evidenced employee H, a home health aide, provided services on 12/13/11 and documented "12/13/11 - I noticed while (5:30 p) changing [patient name] brief that sore on [patient] bottom / coccyx looked red, blue / black. [patient] told me it had been there awhile. I notified [name of director of nursing] by phone at 6 PM."

D. The record evidenced receipt of a prescription via facsimile on 12/15/11 from the attending physician also dated 12/15/11 which stated, "Daily nurse visits. Daily Foley flush. Eval + [and] tx [treatment] for PT [physical therapy] / OT [occupational therapy] / Speech."

E. The record evidenced a document titled "Physician Orders" dated 12/15/11 written by employee E which stated, "T.C. [telephone call] to Dr. [name] office, spoke with [name] RN. Informed we had received the orders for skilled care but needed clarification on orders regarding daily nurse visits with daily Foley flush. Informed [name] a plan of care would be created but that plans for skilled nursing visits would be set for 1 visit weekly for wound assessment and education, and for Foley cath [catheter] flush and education provided to the patient and HHA's [home health aides] for assistance with the flush. [name] stated she did not think MD would object to this order and would relay this info [information] to MD. Asked [name] to call office if this would be a problem. [name] verbalized understanding."

F. The record evidenced a document titled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 42 "Nursing Clinical Progress Notes" dated 12/15/11 from 5 PM through 6:15 PM, completed by employee F, which stated, "Wound Care: Coccyx area cleansed Tegaderm applied. Instructed caregiver on wound care. ... Reinforced pressure relieved methods to improve skin integrity." Attached to the skilled nurse visit note was another document titled "Wound Care Flow Sheet" which stated, "Wound Location Left Coccyx, type ... X pressure assessment date 12/15/11 stage / grade 2 LXWXD in CM 0.2 X 0.3 cm / 2 cm X 2 cm surrounding red area ... undermining N Tunneling N odor 0 % Red 100% ... periwound (surrounding skin) describe - Deep Red non blanching treatment / protocol Tegaderm." This visit note indicated there was only one wound on 12/15/11. The clinical record failed to evidence an order for the Tegaderm at the time of the visit. G. The record evidenced a document titled "Physical Therapy Evaluation and Physician's Certification & Discharge Summary" dated 12/20/11 that stated, "Home evaluation X Alone ... caregivers BID [twice a day]. ... Feeding Independent with set up. ... Patient had partial paralysis and decreased bowel and bladder control from prior back injury, CVA 5-4-11, 7 [unknown] months at SNF [skilled nursing facility]. Pt [patient] has catheter and no bowel control. [patient] is home alone middle of day and all night with call button." The evaluation included an area titled "Functional Status" which the assessor identified and documented that the patient required moderate assistance to roll to left in bed, assume sitting position, transfers to tub / shower, transfers to toilet, sit to stand, personal hygiene, and bathing; and was identified as dependent on others for toileting and dressing lower and upper body.	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 43 H. The record evidenced a document titled "Home Health Certification and Plan of Treatment" with start of care 12/15/11 through 02/12/12, Principle Diagnosis Right flaccid hemiparesis, addition diagnosis, CVA aftercare, and included orders for "SN [skilled nurse] 1 wk [week] 3, 0 [zero] wk [week] 5, 1 wk [week] 1, HHA [home heath aide] 2 X [times] daily - 3 hr [hour] / am, 2 hr / pm - total = 5 hrs / daily. PT - eval and treat, OT - eval and treat, ST [speech therapy] - eval and treat, MSW [medical social worker] - eval and assist. ... Skilled Nursing Orders: ... 2. Flush Foley catheter daily with 3 cc .9% NS [normal saline]. 3. Patient to flush catheter with assist of trained HHA and education provided on proper flushing technique. 4. Tegaderm to coccyx wound. Change 3 times weekly and PRN [as needed]. Trained HHA may apply. May use wound cleanser. ... Home Health Aide Orders: ... May reapply Tegaderm to wound once competencied and under nursing supervision. ... Skilled Nursing Goals: ... 2. Patient and home health aides will be able to return demonstrate proper catheter flushing techniques within 1 week. 3. Patient's wound will heal without complications by end of certification period. ... Veterans Administration Medical Clinic ... to draw PT / INR [Prothrombin Time / International Normalized Ratio] and send results to patient's PCP [primary care physician]. Next PT / INR to be drawn January 3, 2012 at 0940." The patient's Medication List was attached to the plan of care and indicated the patient was ordered warfarin 3 milligrams daily. The plan of care had an attached cover sheet facsimile dated 12/21/2011 which stated, "[name] There are 9 pages to this 485. ... Please have Dr. [name] look this over, sign, and date the 2nd page." The record failed to evidence the patient was	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 44	N 520		

evaluated and demonstrated ability to participate in the ordered catheter flushes, which steps of the flushes the patient was capable of completing independently and which tasks the patient was to receive assistance from the aides. The record failed to evidence there was participation of any other caregivers, family, volunteer, or other hired help, other than from BrightStar, that was committed to participate in patient care and was trained to assist or complete the wound care and catheter flushes with or for the patient.

I. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee H, dated 12/21/11, that stated, "12/21/11 5:00 p - 7:10 P ... flushed [name] catheter 3 cc [cubic centimeter]."

J. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee H, dated 12/23/11, that stated, "12/23/11 4:30 PM ... [name of employee E] instructed me to measure wounds, appearance & [and] pain (if any)."

K. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee J, dated 12/24/11, that stated, "Flushed cath [catheter] 3 cc NS [normal saline]. ... replaced Tegaderm to L [left] heel."

L. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee K, dated 12/25/11, that stated, "Noted little blood on cath [catheter] coming from urethra, called RN [director of nursing] at 5:56 PM. Told to keep eye on it. Will check tomorrow."

M. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 45	N 520		

employee K, note dated 12/26/11 that stated, "Cath [catheter] cleaned, drained, flushed. ... 12/29/11 ... cath [catheter] flush 30 cc saline solution. .... Coccyx Tegaderm intact and clean. applied Tegaderm to L [left] ankle blister 2 cm long. ... 12/29/11 5 PM ... Bilateral swelling of feet L [left] ankle blister 2.5 cm in diameter, spoke to [director of nursing] told about changes in blister. ... 12/30/11 ... L [left] ankle 2.5 centimeter no swelling, covered with Tegaderm. ... cath [catheter] care and flush." The an additional note was written and stated, "12/26/11 Late entry. T.C. [telephone call] regarding blood at Foley site. States no active bleeding. Has resolved." The note was signed by employee E.

N. The record evidenced a document titled "Initial Contact and Order Form" dated 12/23/11 which stated, "Increase Foley cath [catheter] flush daily to 30 CC [cubic centimeter] .9% NS [normal saline]." The document was signed by the director of nursing.

O. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee H, that stated, "12/27/11 10:30 AM ... [patient's name] Tegaderm got soiled ... changed Tegaderm according to [name of director of nursing] instructions. ... 12/28/11 8 a ... I noticed a blister on [patient's name] left foot ... he / she said it was probably from his shoes. W: 2.5 cm L: 2 cm. Called [director of nursing] at 9:45 a to report it. [name of director of nursing] instructed me to put a piece of Tegaderm on it, so I did."

P. The record evidenced a black and white photograph identified as the patient by name and date of birth with stated, "Taken 12/28/11 at 10 AM, by [employee H] CNA / HHA W [width] 2.5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 46	N 520		

cm L [length] 2.0 cm. Fluid filled. Able to blanch the skin surrounding blister. No active drainage noted. Request orders sent to Dr. [attending physician] to apply Tegaderm and allow trained HHA's to apply and report any changes to nursing supervisor." The narrative was signed by the director of nursing and dated 12/28/11.

Q. The record evidenced a document titled "Physician Orders" dated 12/28/11 requesting an order and stated, "Request Order to apply Tegaderm to fluid filled blister to L [left] heel measuring 2.5 cm W 2.0 cm L. Able to blanch surrounding tissue. Blister intact. No active drainage noted. HHA's may be trained to apply Tegaderm and report any changes to nursing supervisor" signed by the director of nursing. The document indicated the facsimile was sent to the attending physician at 12:20 PM on 12/28/11. The order was signed by the attending physician and dated 12/28/11. The order was noted as received by the director of nursing (DON) and dated 12/29/11. The record failed to evidence a skilled nurse assessed the patient and the wounds.

R. The record evidenced document titled "Weekly CNA / HHA Notes" signature of employee H and stated, "12/27/11 6 P I flushed [patient's name] with 30 cc [cubic centimeter] as [name of DON] instructions ... While getting [patient] ready for bed, ... right side was causing [patient] a lot of pain. [patient] asked for medication so I gave him 1 hydrocodone. I notified [DON] at the end of the shift. 12/28/11 6:30 P I flushed [patient] catheter with 30 cc as instructed by [DON]. [patient] Tegaderm on [his / her] bottom and foot were still intact."

S. The record evidenced a document titled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 47 "Nursing Clinical Progress Notes" dated 12/30/11 that documented employee F completed the nurse visit between 1 PM through 1:45 PM and included three documents titled "Wound Care Flow Sheet." i.) Document #1 stated, "Wound Location Coccyx midline, type ... X pressure, assessment date 12/30/11 stage / grade 2 ... wound in size :0.5 X 0.5 cm ... exudate ... none ... undermining N [no] Tunneling N [no] odor none % Red 100% ... granulation N ... periwound (surrounding skin) describe Red blanchable treatment / protocol cleanse soap H 2 O [water] ... Dressing Tegaderm." ii.) Document #2 stated, "Wound Location right coccyx, type ... X pressure, assessment date 12/30/11 stage / grade II ... LXWXD [length, width, depth]: 2.5 X 1.5 ... exudate ... none ... undermining N [no] Tunneling N [no] odor none % Red 100% ... granulation N ... periwound [surrounding skin] describe Red blanchable, treatment / protocol cleanse H 2 O / soap cover Tegaderm. Instruction Given Pressure relief bony prominence's, ... discussed use of heel protectors, patient states does not want to use at this time if area will [unknown]. Verbalized Understanding Partial Understanding." iii.) Document # 3 stated, "Wound Location left ankle lateral, type [not indicated] ... assessment date 12/30/11, stage / grade blister intact, ... LXWXD [length, width, depth]: 2.5 X 2.5 ... exudate ... fluid filled not draining, ... undermining N [no] Tunneling N [no] odor none ... granulation N ... periwound (surrounding skin) describe intact, treatment / protocol Tegaderm. Instruction Given Protect heels, heel	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 48 protector ordered. Patient states will not wear." T. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee L, dated 12/31/11, which stated, "Called [DON] because [patient] penis was swollen and urine was yellowish and thick." An additional narrative was added to the aide note and stated, "12/26/11 late entry. T. C. from [employee L] was informed of swollen penis and urine assessment. Instructed [employee L] to clean penis ... Also informed would be changing catheter net week. [employee L] verbalized understanding." The DON signed the note and signed and dated the "Weekly" document "1/3/12." U. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee L, dated 12/31/11 5 PM, and stated, "Changed Tegaderm on [patient] left foot, penis isn't as swollen this am ... called [DON] she told me what I needed to do." V. The record evidenced a document titled "Nursing Clinical Progress Notes" dated 1/2/12 at 5:30 AM and indicated the visit was a PRN (if necessary) visit, signed by employee E. The document states, "T.C. from patient, states catheter not draining properly and having pain. ... Changed Foley ... inserted without difficulty obtained yellow cloudy urine with large amount of sediment. Patient states pain relieved with catheter change." W. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee L, dated 1/2/12, which stated, "Got specimen [DON] needed."	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 49 X. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of employee H, dated 1/3/12, which stated, "1/3/12 8 a changed [patient] Tegaderm patches on [his / her] bottom and left foot. 1/3/12 - 9 a. [patient] was complaining of severe stomach cramps. [patient] said [patient name] felt like [he / she] needed to have a bowel movement but couldn't. I informed nurse [DON] she instructed me to give him 2 laxative pills after he got home from a 9:40 a Dr appointment, so I did give him the pills at 10 am." Y. The record evidenced a document titled "Weekly CNA / HHA Notes" and signature of employee H, dated week of 1/2/12, and stated, "1/3/12 6 P [patient] speech was a little more difficult to understand than normal. [patient] was saying words but meaning something else. ... I replaced [patient] soiled Tegaderm patch on his bottom. I flushed [patient] catheter using 30 cc as instructed by [DON]. 1/4/12 6:30 P I replaced [patient] Tegaderm on his bottom. I flushed [patient] using 30 cc [cubic centimeter] as instructed by [DON]. I put [patient] heel pillow on ... left foot." Z. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/2/12, and stated, "1/5/12 Blister of Left heel 3 centimeter, Tegaderm applied. ... told by RN [DON] to use Skintegrity to clean wounds. ... Cleaned wound with Skintegrity, placed new Tegaderm. L [left] heel 3 cm still covered with Tegaderm. ... 1/6/12 ... Tegaderm clean and intact heel and coccyx, ... Boot put on L [left] foot." AA. The record evidenced a document titled "Weekly CNA / HHA Notes" signature of	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 50	N 520		

employee L, dated 1/7/12, and stated, "Cath [catheter] care flush 30 cc."

BB. The record evidenced document titled "Weekly CNA / HHA Notes" with signature of employee L, dated week of 1/2/12, Sunday 1/8/12, and stated, "Gave [patient] bath getting ready to flush [patient] and little thing on side of end of cath [catheter] broke off."

CC. The record evidenced a document titled "Weekly CAN / HHA Notes" and signature of employee L, dated week of 1/9/12, and stated, "1/10/12 ... Spoke to RN [DON] about the arrival of acetic acid and other supplies. Instructed to use acetic acid 30 ml for cath [catheter] flush, wrote in spiral as well. ... 1/11/12 ... small bowel movement, cleaned wound, new Tegaderm. ... Drove to wound care apt. [appointment] . Instructed [patient] to wear boots 24 / 7 and dressings of collagen with silver changed every three days. Copy of orders in black folder with binder and office."

DD. The clinical record evidenced documentation from the wound center dated 1/11/12 that stated, "Wound # 1 Wound location: Coccyx, pressure ulcer, ... measurements L X W X D(cm) 4.5 X 7.5 X 0.2 ... stage 2. ... Wound # 2 ... location - left lateral heel, pressure ulcer, date acquired 12/29/11 ... 1.8 X 2.1 X 0.1."

EE. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee H, dated week of 1/9/12, and stated, "1/11/12 ... 6:00 P When getting [patient] ready for bed, I noticed blood coming out of [patient] penis. ... I flushed [patient] catheter using 30 cc ... I reported to [DON] at 6:30 P 1/11/12. She said what I did was fine and the bleeding should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 51 subside by tomorrow morning. ... 1/14/12 6 PM, flushed catheter using 30 cc as directed by [DON]. 6:30 P I called and informed [DON] that [patient] was bleeding out of [patient] penis and had a blister on the 2 cm scratch on [patient] penis. ... [DON] told me the bleeding should subside and to leave the blister alone." FF. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/9/12, and stated, "1/12/12 ... note 2 cm in length superficial wound on penis. ... 30 cc flush with acetic acid." GG. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee L, dated week of 1/16/12, and stated, "On 1/16/12 cath [catheter] flush 30 cc acetic acid. ... 1/17/12 ... cath [catheter] flush 30 cc acetic acid. 1/18/12 ... cath [catheter] flush 30 cc acetic acid." HH. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee H, dated week of 1/16/12, and stated, "1/18/12 6 P, urine output 100 cc. Flushed [patient] catheter using 30 cc instructed by [DON]." II. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/16/12, and stated, "1/17/12 Multiple BM total of 4 round medium size balls, the rest runny. Put Tegaderm on wound. ... 1/19/12 ... no BM ... put new Tegaderm on ankle. ... 1/20/12 ... PT and I set up low air loss mattress, still needs to be adjusted for [patient]. ... 1/21/12 [patient] able to self transfer while bed set at # 2, to wheelchair."	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 52 JJ. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/16/12, and stated, "1/19/12 flushed cath [catheter] with 30 cc acetic acid ... 1/20/12 [patient] in new low air loss mattress. min # 5 to get into bed. Flushed cath [catheter] with 30 cc acetic acid. Bed set on #4." KK. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee K, document dated week of 1/23/12, and stated, "1/25/12 ... all BM's liquid ... transported on the wound care apt. [appointment]. 2 BM liquid while there. Upon arriving back at house [patient] had a BM liquid. Cleaned. ... 1/26/12 ... No BM applied Tegaderm to L heel. Mixed polythylene Glycol (17g) into glass of milk with breakfast. ... 1/27/12 ... Replaced Tegaderm on (L) heel and coccyx. Cleaned up BM [bowel movement] liquid from overnight. [patient] mod second BM ... solid mixed with liquid. Cleaned up. getting [patient] dressed and [patient] had BM solid and large." LL. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/23/12, and stated, "1/26/12 ... [patient] speech trouble finding correct words. ... Flushed cath [catheter] with 30 cc." MM. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee L, dated week of 1/23/12, and stated, "On 1/27/12 emptied 200 cc out of [patient] cath [catheter] at 6:45 PM urine was dark yellow in color. ... 1/28/12 ... 5-7 p ... done peri / cath [catheter] care flush w/ 30 cc acetic acid. ... 1/29/12 5 - 7 P emptied 400 cc out of cath [catheter] and flushed with 30 cc acetic acid."	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 53 NN. The record evidenced a document titled "Weekly CNA / HHA Notes" with signature of employee G, dated week of 1/30/12, and stated, "2/1/12 Pt [patient found unresponsive due to possible stroke. drooling and gargling on right side of mouth 911 called, [DON] called. Sediment in cath [catheter] tube. Paramedics arrived and pt taken to ER." OO. The hospital provided report titled "ED Physician Progress Note" dated 2/1/12 at 9:40 that stated, "Labs are remarkable for slight leukocytosis with evidence of a UTI. Blood and urine cultures were obtained. ... though he does have a UTI this likely is not the direct result of his altered mental status and an ischemic stoke may not be seen." The hospital IP - Discharge Summary" stated, "Repeat CT was done on the morning of 2/2/2012, which, indeed, showed a large evolving acute infarct in the right caudate head and basal ganglia with mass effect and petechial hemorrhaging." The "Inpatient Hospital Discharge Summary" dated 2/2/2012 stated, "Discharge Diagnosis : 1) Large evolving acute infarct of the right caudate head and basal ganglia with mass effect and petechial hemorrhaging. 2) Altered mental status, lethargy, and encephalopathy. 3) Urinary Tract infection with chronic indwelling Foley. 4) Systemic inflammatory response syndrome." PP. The record evidenced an undated letter which stated, "To whom it may concern, "[Patient] has been our patient since December 8, 2011. ... He is now wheelchair bound and had an indwelling catheter. He has 3 wounds, 2 of which were present when he became our patient (bilateral sacral). The third wound is on the outside left heel (intact blister). We have ordered	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 54 an low air - loss mattress from the VA but it has yet to arrive. And now has pressure relief boots he wears at bedtime. ... [patient] brother [name] is POA [power of attorney] and can answer questions you may have, ... [POA] are now in Florida for the winter so our aides will be transporting [patient] to and from appointments." The letter was signed by the DON. QQ. The policy titled "Section 02.02 - Intake Referral and Admission Acceptance and Criteria" states, "There must be a reasonable expectation that the patient's home care needs can be adequately met in the patient's home. Reasonable expectation shall consider: 1) Whether the agency's personnel and resources are adequate and suitable for providing the services the patient requires, 2) The attitudes of patient / caregiver toward acceptance of home care. 3) The patient and / or caregivers ability and willingness to provide interim care when the agency staffs are not present, as needed, .. 5) Whether the patient's needs can be safely and adequately met in the home setting. This includes ongoing availability of personnel and equipment and a plan to meet medical emergencies as well as whether the physical facilities in the patient's home are adequate for giving the client proper care." RR. On February 17, 2012, at 3 PM, the director of nursing indicated the documentation evidenced the patient's wounds increased in size and number after admission and the plan of care did not evidence the nurses were scheduled and responsible for the daily catheter flushes and wound care, but the plan of care indicated the aides were to complete. She indicated the aides were to cover the wounds if the dressing fell off or were soiled until the next skilled nurse visit, and	N 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 520	Continued From page 55 that was as written on the plan of care once a week for the first 3 weeks, then zero times for the next 5 weeks, and then once during the last week of the certification period. She confirmed that there were no skilled nurse visits made to provide care to the patient between December 15 and December 30, 2012, and then the visits occurred weekly thereafter. She further indicated the patient was discharged from the skilled nursing facility in December 2011 and that she was not sure of the date the POA and caregivers left the area and went to Florida.	N 520		
N 522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on clinical record and policy review, and interview, the agency failed to ensure visits and treatments that were provided followed a written plan of care for 2 of 3 records reviewed of patients receiving skilled services (# 's 1 and 3) with the potential to affect all the agency's patients. Findings include: 1. Clinical record # 1, consent for treatment dated 2/5/12, a verbal order dated 1/30/12 that stated, "Physical Therapy to evaluate and treat starting week of January 30, 2012," evidenced a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary"	N 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 522	Continued From page 56 dated 2/5/12 completed by a contracted therapist. The record failed to evidence a written plan of care was developed and implemented. A. On 2/15/12 at 3 PM, employee E indicated there was not a plan of care developed and indicated that she had just received the therapy evaluation document the morning of 2/15/12. B. During a home visit on 2/16/12 at 12 PM, the patient indicated that employee M completed the physical therapy evaluation and provided PT services and those services were planned for every Tuesday and Thursday. Employee O, a physical therapy assistant, provided physical therapy services to the patient. 2. Clinical record # 3, with consent for treatment dated 2/11/12, included a PT evaluation and documentation of treatment dated 2/11/12. The record failed to evidence a written plan of care. A. On 2/15/12 at 4 PM, employee E indicated that patient #3 was not a current patient because she did not have any information on the patient and also indicated that a contracted physical therapist had gone to the patient's home on behalf of the agency. At 4:30 PM' employee E indicated she was not aware she had the PT evaluation for the patient and indicated she had received the therapy evaluation document the morning of 2/15/12. B. During a home visit on 2/17/12 at 11 AM, the patient indicated employee M completed the physical therapy evaluation and provided PT services. During the home visit, employee O, a physical therapy assistant, provided physical therapy services to the patient.	N 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 522	Continued From page 57 3. The policy titled "Section 02.09 Physician Orders - Verbal Orders" states, Policy: Drugs and treatments are administered by BrightStar Care staff only as directed by a physician. Procedure: Orders for patient care are obtained from the physician, either verbally or in writing. Verbal orders may be taken by licensed staff. ... When a verbal order is received, the order must be written down. ... All orders include: ... the specific order. The original order is submitted to the agency within 24 hours after receipt. ... A copy will remain in the patients record until signed order is returned." 4. The policy titled "Section 02.09 - Admission Assessment Visit" states, "The supervising nurse or designated alternate makes the initial admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visits are completed with 48 hours of referral, ... but may be delayed as documented per patient / family request and / or physician orders regarding start of care. When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care. An admission assessment visit can be performed without doctor's orders to evaluate whether home care is needed if no "hands on" care is provided." 5. On 2/15/12 2:10 PM, employee E indicated the skilled disciplines were not to contact the physician for orders, she was to obtain the evaluation and write the plan of care, send to the physician for signature, and when the plan of care was returned signed, then the agency had physicians orders. She indicated until the signed plan of care returns, they are operating under the "eval and treat" order.	N 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 524	Continued From page 58	N 524		
N 524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure a medical plan of care was developed for 2 of 3 clinical records reviewed in which the patient was provided with a skilled service. (#'s 1 and 3) Findings include: 1. Clinical record # 1, consent for treatment dated 2/5/12, a verbal order dated 1/30/12 that stated,	N 524		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 524	Continued From page 59 "Physical Therapy to evaluate and treat starting week of January 30, 2012," evidenced a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/5/12 completed by a contracted therapist. The record failed to evidence a written plan of care was developed and implemented. A. On 2/15/12 at 3 PM, employee E indicated there was not a plan of care developed and indicated that she had just received the therapy evaluation document the morning of 2/15/12. B. During a home visit on 2/16/12 at 12 PM, the patient indicated that employee M completed the physical therapy evaluation and provided PT services and those services were planned for every Tuesday and Thursday. Employee O, a physical therapy assistant, provided physical therapy services to the patient. 2. Clinical record # 3, with consent for treatment dated 2/11/12, included a PT evaluation and documentation of treatment dated 2/11/12. The record failed to evidence a written plan of care. A. On 2/15/12 at 4 PM, employee E indicated that patient #3 was not a current patient because she did not have any information on the patient and also indicated that a contracted physical therapist had gone to the patient's home on behalf of the agency. At 4:30 PM' employee E indicated she was not aware she had the PT evaluation for the patient and indicated she had received the therapy evaluation document the morning of 2/15/12. B. During a home visit on 2/17/12 at 11 AM, the patient indicated employee M completed the physical therapy evaluation and provided PT	N 524		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 524	Continued From page 60 services. During the home visit, employee O, a physical therapy assistant, provided physical therapy services to the patient. 3. The policy titled "Section 02.13 - Clinical Record and Documentation" states, "A clinical record will be maintained for each patient receiving home health services from the agency. Each record shall contain at least the following: The medical plan of care and appropriate identifying information, ... drug, dietary, treatment and activity orders." 4. The policy titled "Section 02.14 - Medical Plan of Care, Physician Orders, and Medical Supervision" states, "Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, chiropractor, optometrist or podiatrist. Be developed in consultation with the agency staff. Include all services to be provided if a skilled service is being provided. Cover all pertinent diagnosis. Include the following: Mental status, Type of services and equipment required, frequency and duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment, any other appropriate items. ... All medications, treatments and services provided to patients must be ordered by a physician. ... The medical plan of care will be used as the care plan and will include reasonable, measurable, and realistic goals as determined by the patient assessment. The care plan will also addresses rehabilitation potential and discharge plans."	N 524		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 527	Continued From page 61	N 527		
N 527	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (#4) Findings include: 1. Clinical record # 4, evidenced a document titled "SK1 - Initial Skilled Client Assessment" dated 12/8/11 and at 5 PM, completed by employee F, which states, "indwelling catheter, hemiparesis, right side weakness, use of assistive device ... slide board, psycho / neurologic alert, oriented person, place, forgetful, ... integumentary ... pressure ulcers Describe Skin Abnormalities: 2 cm [centimeter] unstageable 100 % covered with slough." The record failed to evidence the physician was notified of the wound once identified or an order for treatment was obtained by the nurse. 2. The record evidenced receipt of a prescription via facsimile on 12/15/11 from the attending physician also dated 12/15/11 which stated, "Daily nurse visits. Daily Foley flush. Eval + [and] tx [treatment] for PT [physical therapy] / OT	N 527		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 527	Continued From page 62 [occupational therapy] / Speech." 3. The record evidenced a document titled "Physician Orders" dated 12/15/11 written by employee E which stated, "T.C. [telephone call] to Dr. [name] office, spoke with [name] RN. Informed we had received the orders for skilled care but needed clarification on orders regarding daily nurse visits with daily Foley flush. Informed [name] a plan of care would be created but that plans for skilled nursing visits would be set for 1 visit weekly for wound assessment and education, and for Foley cath [catheter] flush and education provided to the patient and HHA's [home health aides] for assistance with the flush. [name] stated she did not think MD would object to this order and would relay this info [information] to MD. Asked [name] to call office if this would be a problem. [name] verbalized understanding." 4. The record evidenced a document titled "Nursing Clinical Progress Notes" dated 12/30/11 that documented employee F completed the nurse visit between 1 PM through 1:45 PM and included three documents titled "Wound Care Flow Sheet." A. Document #1 stated, "Wound Location Coccyx midline, type ... X pressure, assessment date 12/30/11 stage / grade 2 ... wound in size :0.5 X 0.5 cm ... exudate ... none ... undermining N [no] Tunneling N [no] odor none % Red 100% ... granulation N ... periwound (surrounding skin) describe Red blanchable treatment / protocol cleanse soap H 2 O ... Dressing Tegaderm." B. Document #2 stated, "Wound Location right coccyx, type ... X pressure, assessment date 12/30/11 stage / grade II ... LXWXD	N 527		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 527	Continued From page 63 [length, width, depth]: 2.5 X 1.5 ... exudate ... none ... undermining N [no] Tunneling N [no] odor none % Red 100% ... granulation N ... periwound (surrounding skin) describe Red blanchable, treatment / protocol cleanse H 2 O / soap cover Tegaderm. Instruction Given Pressure relief bony prominence's, ... discussed use of heel protectors, patient states does not want to use at this time if area will [unknown]. Verbalized Understanding Partial Understanding." C. Document # 3 stated, "Wound Location left ankle lateral, type [not indicated] ... assessment date 12/30/11, stage / grade blister intact, ... LXWXD [length, width, depth]: 2.5 X 2.5 ... exudate ... fluid filled not draining, ... undermining N [no] Tunneling N [no] odor none ... granulation N ... periwound (surrounding skin) describe intact, treatment / protocol Tegaderm. Instruction Given Protect heels, heel protector ordered. Patient states will not wear." D. The record failed to evidence the attending physician was informed of the status of the patient's wounds on the coccyx. 5. The record evidenced a document titled "Nursing Clinical Progress Notes" dated 1/2/12 at 5:30 AM and indicated the visit was a PRN visit, document was signed by employee E. The document states, "T.C. from patient, states catheter not draining properly and having pain. ... Changed Foley ... inserted without difficulty obtained yellow cloudy urine with large amount of sediment. Patient states pain relieved with catheter change." The record failed to evidence the physician was informed about the cloudy urine with sediment. 6. The record evidenced a document titled	N 527		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 527	Continued From page 64 "Physicians Orders" dated 1/4/12 and signature of employee E and stated, "Request orders to change dressing on coccyx wounds to an anti microbial silver dressing every 5 days per manufactures recommendations, and PRN for soilage. HHA's may be trained and able to change and report any changes to patient's health status to supervisor." The attending physician signed the request and dated 1/4/12 and added a note that stated, "I was not aware of coccyx wounds. Please arrange consult with Dr. [name]." 7. The record evidenced document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/9/12, and stated, "1/12/12 ... note 2 cm in length superficial wound on penis. ... 30 cc flush with acetic acid." The record failed to evidence the physician was notified of the wound on penis. 8. On February 17, 2012, at 3 PM, the director of nursing indicated that the documentation indicated that the patients wounds increased in size and number after admission and that she did not have any other documentation to evidence that the attending physician was made aware of the increasing size and number of wounds. She said she spoke to the attending physician's nurse.	N 527		
N 533	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.	N 533		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 533	Continued From page 65 (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. This REQUIREMENT is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the clinical records included a nursing plan of care for 3 of 3 patient records reviewed of patients receiving home health aide only services. (#'s 2, 4, and 5) Findings include: 1. Clinical record #2, with assessment by the registered nurse dated 2/7/12, failed to evidence a nursing plan of care with all the required items. The clinical record evidenced a document titled "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" dated 2/7/12 which failed to evidence the patient's physician, the services to be provided, the frequency and duration of the visit, and the patient's medications and activities. During a home visit on 2/16/12 at 1:30 PM, the caregiver indicated the patient began receiving aide services on 2/13/12.	N 533		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 533	Continued From page 66 2. Clinical record # 4, evidenced a document titled "Initial Phone Call Assessment - INTAKE FORM" which indicated the a family member called the agency October 20, 2011 and states, "Had a stoke in May, has hemiparesis on right side, can move and standup but can dress self, ... need someone every day get down, get up, ... need someone full time, because family leaves for Florida." A. The record evidenced documents titled "Weekly CNA / HHA Notes." The record evidenced employee K, home health aide, provided services to the patient on behalf of the agency on 12/8/11 beginning at 8 AM. B. The record evidenced a document titled "SK1 - Initial Skilled Client Assessment" dated 12/8/11 and at 5 PM, completed by employee F, home health aide, which states, "Indwelling catheter, hemiparesis, right side weakness, use of assistive device ... slide board, psycho / neurologic alert, oriented person, place, forgetful, ... integumentary ... pressure ulcers Describe Skin Abnormalities: 2 cm [centimeter] unstageable 100 % covered with slough." C. The record evidenced a document titled "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" dated 12/8/11, the discipline assigned was a home health aide. The services that were assigned to be performed by the aide were hygiene - bed - partial / complete daily, shampoo hair as needed, mouth care daily, shave electric as needed, skin care daily, dressing daily, catheter care daily, assist with feeding, and turning and repositioning every 2 hours. The document included the signature of employee F.	N 533		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 533	Continued From page 67 D. On 2/16/12 at 2:50 PM, employee E indicated the home health aide entered the home and provided services before the nurse assessed the patient because the agency had not received the signed physician orders until 12/15/11. 3. Clinical record #5, with first patient care date of 12/8/11, failed to evidence a nursing plan of care. The clinical record evidenced a document titled "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" dated 11/1/11. A. The clinical record evidenced employee G provided aide services on 12/14/11 and employee P provided aide services on 12/8/11, 12/9/11, 12/12/11, 12/13/11, 12/14/11, 12/15/11, 12/16/11, 12/17/11, 12/18/11, 12/21/11, 12/23/11, and 12/24/11. B. On 2/17/12 at 10:20 AM, employee E indicated the patient was a readmit and she used the previous information from the 11/1/11 admission. There was not an assessment by the registered nurse prior to the aide rendering care. 4. On 2/17/12 at 1 PM, the Director of Nursing indicated she used an agency document identified as "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" as the nursing plan of care and the service agreement for attendant care services. She indicated the nursing care plan for clinical record # 2 did not include all the required items and that there was no further documentation. 5. The policy titled "Section 02.11 - Nursing Plan of Care" states, "A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care	N 533		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 533	Continued From page 68 provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service."	N 533		
N 540	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. This RULE is not met as evidenced by: Based on clinical record and policy review, and interview, the agency failed to ensure the registered nurse made an initial assessment visit to identify the patients' immediate care needs as required by agency policy for 3 (#'s 1, 3, and 5) of 5 clinical record reviewed. Findings include: 1. Clinical record # 1 evidenced a referral dated 1/30/12 and a physician order dated 1/30/12 that stated, "Physical Therapy to evaluate and treat starting week of January 30, 2012." The record failed to evidence an initial assessment visit was completed within 48 hours of the agency receiving the referral. The record evidenced an incomplete assessment was completed by employee M, the physical therapist, dated 2/5/12. The record failed to evidence a comprehensive assessment. 2. Clinical record # 3 evidenced a referral dated 2/6/12 and a physician order dated 2/6/12 that stated, "Request orders for Physical Therapy to evaluate and treat starting week of 2/6/12." The	N 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 540	Continued From page 69 record failed to evidence an initial assessment visit was completed within 48 hours of the agency receiving the referral. 3. Clinical record # 5, first date of patient care 12/8/11, failed to evidence an initial assessment by the registered nurse. The clinical record evidenced a document titled "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" dated 11/1/11. A. The clinical record evidenced employee G provided aide services on 12/14/11 and employee P provided aide services on 12/8/11, 12/9/11, 12/12/11, 12/13/11, 12/14/11, 12/15/11, 12/16/11, 12/17/11, 12/18/11, 12/21/11, 12/23/11, and 12/24/11. B. On 2/17/12 at 10:20 AM, employee E indicated the patient was a readmit and she used the previous information from the 11/1/11 admission. There was not an assessment by the registered nurse prior to the aides rendering care. 4. The undated policy titled "Section 02.09 - Admission Assessment Visit" stated, "An initial assessment must be completed with the identification of patient needs before home care services can be rendered. The supervising nurse or designated alternate makes the initial admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visits normally are completed within 48 hours of referral, ... may be delayed as documented per patient / family request and / or physician orders regarding start of care. ... An admission visit can be performed without doctor's orders to evaluate whether home care is needed of no "hands on" care is provided."	N 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 540	Continued From page 70 5. The undated policy titled "Section 02.10 - Skilled Nursing Services" stated, "Registered nurses do the following: Perform initial admission assessments." 6. On February 15, 2012, at 11:21 AM, employee E indicated the initial assessment was to be completed within a week of the physicians' order. 7. On February 16, 2012, at 10 AM, employee E indicated she did not send skilled disciplines to any patient's home to evaluate for services until the agency had received signed physician orders to evaluate and treat the patient.	N 540		
N 542	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. This RULE is not met as evidenced by: Based on clinical record and policy review, observation, and interview, the agency failed to ensure the registered nurse established a plan of care for 4 of 5 clinical records reviewed. (# 1, 2, 3, and 5) Findings include: 1. Clinical record # 1, consent for treatment dated 2/5/12, included a verbal order dated 1/30/12 that stated, "Physical Therapy (PT) to evaluate and treat starting week of January 30, 2012." The record contained a document titled "Physical Therapy Evaluation & Physicians	N 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 542	Continued From page 71 Certification & Discharge Summary" dated 2/5/12 completed by a contracted therapist. The record failed to evidence the registered nurse had completed and initiated a plan of care. A. On 2/15/12 at 3 PM, employee E indicated there was not a plan of care developed and she had just received the therapy evaluation document the morning of 2/15/12. B. During a home visit on 2/16/12 at 12 PM, the patient indicated employee M completed the physical therapy evaluation and provided PT services and those services were planned for every Tuesday and Thursday. During the home visit, employee O, a physical therapy assistant, provide physical therapy services. 2. Clinical record #2, first date the aide provided care was 2/13/12, failed to evidence the registered nurse had developed and implemented a plan of care. On 2/17/12 at 1 PM, the Director of Nursing indicated she used an agency document identified as "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" as the nursing plan of care and as the service agreement for attendant care services. She indicated the nursing care plan for clinical record # 2 did not include all the required items and there was no further documentation. 3. Clinical record # 3, with consent for treatment dated 2/11/12, included a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/11/12. The record failed to evidence a written plan of care.	N 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 542	Continued From page 72 During a home visit on 2/17/12 at 11 AM, the patient indicated employee M completed the physical therapy evaluation and provided PT services. During the home visit, employee O, a physical therapy assistant, provide physical therapy services to the patient. 4. Clinical record #5, first date the aide provided care was 12/8/11, failed to evidence the registered nurse had developed and implemented a a plan of care. On 2/17/12 at 10:20 AM, employee E indicated patient #5 was a readmit and she used the previous information from the 11/1/11 admission. There was not a plan of care developed by the registered nurse. 5. The policy titled "Section 02.13 - Clinical Record and Documentation" states, "A clinical record will be maintained for each patient receiving home health services from the agency. Each record shall contain at least the following: The medical plan of care and appropriate identifying information, ... drug, dietary, treatment and activity orders." 6. The policy titled "Section 02.14 - Medical Plan of Care, Physician Orders, and Medical Supervision" states, "Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, chiropractor, optometrist or podiatrist. Be developed in consultation with the agency staff. Include all services to be provided if a skilled service is being provided. Cover all pertinent diagnosis. Include the following: Mental status, Type of services and equipment required, frequency and duration of visits, prognosis, rehabilitation potential, functional limitations,	N 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 542	Continued From page 73 activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment, any other appropriate items. ... All medications, treatments and services provided to patients must be ordered by a physician. ... The medical plan of care will be used as the care plan and will include reasonable, measurable, and realistic goals as determined by the patient assessment. The care plan will also addresses rehabilitation potential and discharge plans."" 7. The policy titled "Section 02.11 - Nursing Plan of Care" states, "A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service."	N 542		
N 546	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse	N 546		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 546	Continued From page 74 informed the physician of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (#4) Findings include: 1. Clinical record # 4, evidenced a document titled "SK1 - Initial Skilled Client Assessment" dated 12/8/11 and at 5 PM, completed by employee F, which states, "indwelling catheter, hemiparesis, right side weakness, use of assistive device ... slide board, psycho / neurologic alert, oriented person, place, forgetful, ... integumentary ... pressure ulcers Describe Skin Abnormalities: 2 cm [centimeter] unstageable 100 % covered with slough." The record failed to evidence the physician was notified of the wound once identified or an order for treatment was obtained by the nurse. 2. The record evidenced receipt of a prescription via facsimile on 12/15/11 from the attending physician also dated 12/15/11 which stated, "Daily nurse visits. Daily Foley flush. Eval + [and] tx [treatment] for PT [physical therapy] / OT [occupational therapy] / Speech." 3. The record evidenced a document titled "Physician Orders" dated 12/15/11 written by employee E which stated, "T.C. [telephone call] to Dr. [name] office, spoke with [name] RN. Informed we had received the orders for skilled care but needed clarification on orders regarding daily nurse visits with daily Foley flush. Informed [name] a plan of care would be created but that plans for skilled nursing visits would be set for 1 visit weekly for wound assessment and education, and for Foley cath [catheter] flush and	N 546		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 546	Continued From page 75 education provided to the patient and HHA's [home health aides] for assistance with the flush. [name] stated she did not think MD would object to this order and would relay this info [information] to MD. Asked [name] to call office if this would be a problem. [name] verbalized understanding." 4. The record evidenced a document titled "Nursing Clinical Progress Notes" dated 12/30/11 that documented employee F completed the nurse visit between 1 PM through 1:45 PM and included three documents titled "Wound Care Flow Sheet." A. Document #1 stated, "Wound Location Coccyx midline, type ... X pressure, assessment date 12/30/11 stage / grade 2 ... wound in size :0.5 X 0.5 cm ... exudate ... none ... undermining N [no] Tunneling N [no] odor none % Red 100% ... granulation N ... periwound (surrounding skin) describe Red blanchable treatment / protocol cleanse soap H 2 O ... Dressing Tegaderm." B. Document #2 stated, "Wound Location right coccyx, type ... X pressure, assessment date 12/30/11 stage / grade II ... LXWXD [length, width, depth]: 2.5 X 1.5 ... exudate ... none ... undermining N [no] Tunneling N [no] odor none % Red 100% ... granulation N ... periwound (surrounding skin) describe Red blanchable, treatment / protocol cleanse H 2 O / soap cover Tegaderm. Instruction Given Pressure relief bony prominence's, ... discussed use of heel protectors, patient states does not want to use at this time if area will [unknown]. Verbalized Understanding Partial Understanding." C. Document # 3 stated, "Wound Location left ankle lateral, type [not indicated] ...	N 546		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 546	Continued From page 76	N 546		

assessment date 12/30/11, stage / grade blister intact, ... LXWXD [length, width, depth]: 2.5 X 2.5 ... exudate ... fluid filled not draining, ... undermining N [no] Tunneling N [no] odor none ... granulation N ... periwound (surrounding skin) describe intact, treatment / protocol Tegaderm. Instruction Given Protect heels, heel protector ordered. Patient states will not wear."

D. The record failed to evidence the attending physician was informed of the status of the patient's wounds on the coccyx.

5. The record evidenced a document titled "Nursing Clinical Progress Notes" dated 1/2/12 at 5:30 AM and indicated the visit was a PRN visit, document was signed by employee E. The document states, "T.C. from patient, states catheter not draining properly and having pain. ... Changed Foley ... inserted without difficulty obtained yellow cloudy urine with large amount of sediment. Patient states pain relieved with catheter change." The record failed to evidence the physician was informed about the cloudy urine with sediment.

6. The record evidenced a document titled "Physicians Orders" dated 1/4/12 and signature of employee E and stated, "Request orders to change dressing on coccyx wounds to an anti microbial silver dressing every 5 days per manufactures recommendations, and PRN for soilage. HHA's may be trained and able to change and report any changes to patient's health status to supervisor." The attending physician signed the request and dated 1/4/12 and added a note that stated, "I was not aware of coccyx wounds. Please arrange consult with Dr. [name]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 546	Continued From page 77 7. The record evidenced document titled "Weekly CNA / HHA Notes" with signature of employee K, dated week of 1/9/12, and stated, "1/12/12 ... note 2 cm in length superficial wound on penis. ... 30 cc flush with acetic acid." The record failed to evidence the physician was notified of the wound on penis. 8. On February 17, 2012, at 3 PM, the director of nursing indicated that the documentation indicated that the patients wounds increased in size and number after admission and that she did not have any other documentation to evidence that the attending physician was made aware of the increasing size and number of wounds. She said she spoke to the attending physician's nurse.	N 546		
N 547	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse carried out the physician orders which were obtained by the agency for the evaluation of the patient for home health services in 3 of 3 clinical records reviewed of patients who which received skilled services. (# 1, 3, and 4) Findings include: 1. Clinical record # 1, consent for treatment	N 547		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 547	Continued From page 78 dated 2/5/12, contained a verbal order dated 1/30/12 that stated, "Physical Therapy to evaluate and treat starting week of January 30, 2012" and evidenced a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/5/12 completed by a contracted therapist. The record failed to evidence any other evaluation was completed by any other discipline or a reason to explain why the verbal order was not carried out. 2. Clinical record # 3 included a verbal order dated 2/6/12 that states, "Request order for physical therapy evaluation and treatment week of 2/6/12." The record evidenced a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/11/12. The record failed to evidence any other evaluation was completed by any other discipline or a reason to explain why the verbal order was not carried out. 3. Clinical record # 4 evidenced the referral was received on 10/20/11 when the patient was receiving skilled services in a skilled nursing facility. Consents for home care services were signed by the power of attorney and dated 12/8/11. The Service Agreement was signed the same day with the services to be provided and listed as "CNA [certified nursing assistant], LPN [licensed practical nurse], RN [registered nurse], HHA home health services], and Medical social services." A verbal order was received from the attending physician for evaluation of home health services and was dated 12/8/11. The record evidenced a plan of care with the start of care date 12/15/11. 4. On 2/16/12 at 2:50 PM, employee E indicated she did not carry out the verbal orders from	N 547		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 547	Continued From page 79	N 547		

physicians for any skilled services until the physician order was signed and returned to the agency and that was why the patients did not have skilled services and evaluations timely as she was waiting for the physician's signature.

5. On 2/17/12 at 2:40 PM, employee E indicated there was not an agency policy or procedure that specified how the agency was to determine the start of care date.

6. The policy titled "Section 02.09 Physician Orders - Verbal Orders" states, Policy: Drugs and treatments are administered by BrightStar Care staff only as directed by a physician. Procedure: Orders for patient care are obtained from the physician, either verbally or in writing. Verbal orders may be taken by licensed staff. ... When a verbal order is received, the order must be written down. ... All orders include: ... the specific order. The original order is submitted to the agency within 24 hours after receipt. ... A copy will remain in the patients record until signed order is returned."

7. The policy titled "Section 02.09 - Admission Assessment Visit" states, "The supervising nurse or designated alternate makes the initial admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visits are completed with 48 hours of referral, ... but may be delayed as documented per patient / family request and / or physician orders regarding start of care. When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 562	Continued From page 80	N 562		
N 562	410 IAC 17-14-1(c) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (1) make an initial evaluation visit to the patient for whom only therapy services are required; This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the physical therapist completed the initial assessment visit within forty eight hours of referral as required by agency policy in 2 of 2 clinical records reviewed of patients receiving physical therapy only. (# 1 and 3) Findings include: 1. Clinical record # 1, consent for treatment dated 2/5/12, included a verbal order dated 1/30/12 that stated, "Physical Therapy to evaluate and treat starting week of January 30, 2012" and a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/5/12 completed by a contracted therapist. The record failed to evidence the therapy evaluation was completed within 48 hours. 2. Clinical record # 3 included with a verbal order dated 2/6/12 that states, "Request order for physical therapy evaluation and treatment week of 2/6/12." The record evidenced a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/11/12. The record failed to evidence the therapy evaluation was completed within 48 hours.	N 562		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 562	Continued From page 81 3. On 2/16/12 at 2:50 PM, employee E indicated she did not carry out the verbal orders from physicians for any skilled services until the physician order was signed and returned to the agency and that was why the patients did not have skilled services and evaluations timely. She was waiting for the physician's signature on the verbal order before sending out a skilled discipline. 4. The policy titled "Section 02.09 - Admission Assessment Visit" states, "The supervising nurse or designated alternate makes the initial admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visits are completed with 48 hours of referral, ... but may be delayed as documented per patient / family request and / or physician orders regarding start of care. When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care."	N 562		
N 572	410 IAC 17-14-1(e) Scope of Services Rule 14 Sec. 1(e) Any social services furnished by the home health agency, shall be provided by a social worker, or a social work assistant under the supervision of a social worker, and in accordance with the medical plan of care. This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure a qualified social worker provided services as ordered in 1 of 1 record reviewed with orders for a social worker. (# 4) Findings include:	N 572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 572	Continued From page 82 1. Clinical record #4 evidenced a document titled "Home Health Certification and Plan of Treatment" dated 12/15/11 through 02/12/12 that identified the patient had a principle diagnosis of right flaccid hemiparesis and an addition diagnosis of CVA aftercare and included orders for "MSW [medical social worker] - eval and assist." The record failed to evidence the MSW provided services to the patient. 2. Personnel file A, a social worker (SW), date of hire 11/1/11 and first patient contact 1/14/12 with patient # 4, failed to evidence the employee met the qualifications of a social worker. 410 IAC 19-9-25 defined a social worker and stated, "means a person who has a master's degree from a school of social work accredited by the Council on Social Work Education." 2. On February 16, 2012, at 10 AM, the director of nursing indicated she did not send any skilled disciplines to the patient homes until the physician had signed the verbal order and it was returned to the agency. 3. On 2/17/12 at 3:15 PM, the director of nursing indicated the order for the SW on the plan of care was "just to have the order." 4. The clinical record evidenced services of the social worker were provided to this patient on 11/1/11, 11/13/11, and 11/21/11, prior to the patient's start of care. The notes indicate the SW assisted the patient / family, while the patient was in the skilled nursing facility, to find the patient a residence. 5. The policy titled "Section 02.09 - Admission Assessment Visit" states, "The supervising nurse	N 572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 572	Continued From page 83 or designated alternate makes the initial admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visits are completed with 48 hours of referral, ... but may be delayed as documented per patient / family request and / or physician orders regarding start of care. When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care. An admission assessment visit can be performed without doctor's orders to evaluate whether home care is needed if no "hands on" care is provided."	N 572		
N 596	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and This RULE is not met as evidenced by: Based on personnel record, clinical record, and document review and interview, the agency failed to ensure, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed (G, H, I, J, K, and L). Findings include: 1. During an interview on 2/15/12 at 12:50 PM, the Director of Nurses indicated she completed	N 596		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 596	Continued From page 84 all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient. 2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number. 3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program" states, "Home Health Aides prior to providing patient service should have the following areas addressed: Successful completion of a competency evaluation program. ... Have documentation which demonstrates successful completion of a competency evaluation." 4. The policy titled "Section 03.13 - Clinical Competency Program" states, "BrightStar Care will access and document the clinical competency of each staff member who provides direct client care, treatment, or services. Each staff member who provides direct client care will have a clinical competency assessment at defined intervals: a. as part of orientation, ... in accordance with laws and regulations."	N 596		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 596	Continued From page 85 5. Employee files G, H, I, J, K, and L included the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant." The skills included on the check list were "1. Temperature - digital thermometers, oral, axillary, temporal, tympanic. 2) Pulse - radial. 3) Pulse - apical. 4) Blood Pressure. 5) respirations., 6) shower / tub bath. 7) bed bath. 8) skin care. 9) oral care. 10) shampoo. 11) toileting / elimination: urinal, bedpan, bedside commode. 12) transfer: bed to chair, chair to standing, assist with ambulation, and other. 13) assists with range of motion. 14) assistive devices: walker, cane, other. 15) positioning. 16) making occupied bed. 17) Miscellaneous skills: Medication reminder, Urinary catheter care, gastrostomy site care, observe / record intake / output, other, and other. ... 27) Meal Preparation: feeding, diabetic diet, low sodium, low cholesterol / fat diets." The form was to be initialed and dated by the individual evaluating the skill. The proficiency method code at the bottom of the page stated, "O" for observation, "D" for demonstration, and "ST" for special training. The list did not include range of motion. 6. Personnel file G, date of hire 6/3/11 and first patient contact 12/14/11 with patient #4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" that documented skills were evaluated on 6/21/11, 8/31/11, 12/7/11, and 1/10/12 (after patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, and 4) meal preparation, diabetic, low sodium, low cholesterol /fat diets. The document evidenced the aide was evaluated as competent in an additional task and written in as "catheter flush" that was not dated. This task is not in the	N 596		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 596	Continued From page 86 scope of practice of the home health aide. 7. Personnel file H, date of hire 5/18/11 and first patient contact 12/13/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" that documented skills were evaluated on 6/7/11, 6/8/11, 8/31/11, 12/13/11, and 12/30/11 (after first patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, urinal, bedpan, or bedside commode, and 5) meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" on 12/13/11 and "basic wound care" 12/20/11. These tasks are not in the scope of practice of the home health aide. 8. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 10/20/11, 12/11/11, and 12/18/11 (after patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) toileting or elimination, urinal, bedpan, or bedside commode, and 4) meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" on 12/18/11. These tasks are not in the scope of practice of the home health aide. 9. Personnel file J, date of hire 11/1/11 and first	N 596		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 596	Continued From page 87 patient contact 12/24/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 11/1/11, 11/9/11, and 12/24/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, urinal, bedpan, or bedside commode, and 4) feeding, or meal preparation of a low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/24/11. These tasks are not in the scope of practice of the home health aide. 10. Personnel file K, date of hire 6/22/11 and first patient contact 12/24/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 7/8/11, 9/8/11, 12/8/11, and 12/15/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, bedpan, or bedside commode, and 4) feeding, or meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/15/11. These tasks are not in the scope of practice of the home health aide. 11. Personnel file L, date of hire 12/28/11 and first patient contact 12/31/11, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 12/30/11.	N 596		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 596	Continued From page 88 The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, and 3) toileting or elimination, bedpan, or bedside commode. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/30/11. These tasks are not in the scope of practice of the home health aide.	N 596		
N 598	410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met. This RULE is not met as evidenced by: Based on personnel record, clinical record, and document review and interview, the agency failed to ensure documentation evidenced, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed (G, H, I, J, K, and L). Findings include: 1. During an interview on 2/15/12 at 12:50 PM, the Director of Nurses indicated she completed all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient. 2. On 2/16/12 at 4:35 PM, employee N, the	N 598		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 598	Continued From page 89 human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number. 3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program" states, "Home Health Aides prior to providing patient service should have the following areas addressed: Successful completion of a competency evaluation program. ... Have documentation which demonstrates successful completion of a competency evaluation." 4. The policy titled "Section 03.13 - Clinical Competency Program" states, "BrightStar Care will access and document the clinical competency of each staff member who provides direct client care, treatment, or services. Each staff member who provides direct client care will have a clinical competency assessment at defined intervals: a. as part of orientation, ... in accordance with laws and regulations." 5. Employee files G, H, I, J, K, and L included the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant." The skills included on the check list were "1. Temperature - digital thermometers, oral, axillary, temporal, tympanic. 2) Pulse - radial. 3) Pulse - apical. 4) Blood Pressure. 5) respirations., 6) shower / tub bath. 7) bed bath. 8) skin care. 9)	N 598		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 598	Continued From page 90 oral care. 10) shampoo. 11) toileting / elimination: urinal, bedpan, bedside commode. 12) transfer: bed to chair, chair to standing, assist with ambulation, and other. 13) assists with range of motion. 14) assistive devices: walker, cane, other. 15) positioning. 16) making occupied bed. 17) Miscellaneous skills: Medication reminder, Urinary catheter care, gastrostomy site care, observe / record intake / output, other, and other. ... 27) Meal Preparation: feeding, diabetic diet, low sodium, low cholesterol / fat diets." The form was to be initialed and dated by the individual evaluating the skill. The proficiency method code at the bottom of the page stated, "O" for observation, "D" for demonstration, and "ST" for special training. The list did not include range of motion. 6. Personnel file G, date of hire 6/3/11 and first patient contact 12/14/11 with patient #4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" that documented skills were evaluated on 6/21/11, 8/31/11, 12/7/11, and 1/10/12 (after patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, and 4) meal preparation, diabetic, low sodium, low cholesterol /fat diets. The document evidenced the aide was evaluated as competent in an additional task and written in as "catheter flush" that was not dated. This task is not in the scope of practice of the home health aide. 7. Personnel file H, date of hire 5/18/11 and first patient contact 12/13/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" that documented skills were evaluated on 6/7/11, 6/8/11, 8/31/11, 12/13/11,	N 598		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 598	Continued From page 91 and 12/30/11 (after first patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, urinal, bedpan, or bedside commode, and 5) meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" on 12/13/11 and "basic wound care" 12/20/11. These tasks are not in the scope of practice of the home health aide. 8. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 10/20/11, 12/11/11, and 12/18/11 (after patient contact). The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) toileting or elimination, urinal, bedpan, or bedside commode, and 4) meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" on 12/18/11. These tasks are not in the scope of practice of the home health aide. 9. Personnel file J, date of hire 11/1/11 and first patient contact 12/24/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 11/1/11, 11/9/11, and 12/24/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination,	N 598		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 598	Continued From page 92	N 598		

urinal, bedpan, or bedside commode, and 4) feeding, or meal preparation of a low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/24/11. These tasks are not in the scope of practice of the home health aide.

10. Personnel file K, date of hire 6/22/11 and first patient contact 12/24/11 with patient # 4, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 7/8/11, 9/8/11, 12/8/11, and 12/15/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, 3) shampoo, 4) toileting or elimination, bedpan, or bedside commode, and 4) feeding, or meal preparation of a diabetic, low sodium, or low cholesterol / fat diet. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/15/11. These tasks are not in the scope of practice of the home health aide.

11. Personnel file L, date of hire 12/28/11 and first patient contact 12/31/11, evidenced the document titled "Competency Assessment Skills Check List for Certified Nursing Assistant" which documented skills were evaluated on 12/30/11. The document failed to evidence the aide was evaluated on 1) range of motion, 2) shower or tub bath, and 3) toileting or elimination, bedpan, or bedside commode. The document evidenced the aide was evaluated as competent in an additional task and written in as "Foley catheter flush" and "basic wound care" and dated 12/30/11. These tasks are not in the scope of practice of the home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING: _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 598	Continued From page 93 health aide.	N 598		